WC-365.1 (R-7-04)

State of New Jersey
Department of Labor and Workforce Development
DIVISION OF WORKERS' COMPENSATION
CN 381
Trenton, New Jersey 08625-0381

EMPLOYEE'S CLAIM PETITION SUPPLEMENTAL PAGE

(DO NOT FILL IN)

CASE NO. ____________________

D.O. ____________________

Date of Accident or Dates of Occupational Exposure:

If Respondent Known By Different Name, Please Indicate Below:

INSURANCE CARRIER

NAME (Indicate if Not Covered or self-insured) NJ REG. OR FEIN	
ADDRESS	
CARRIER'S CLAIM FILE NUMBER	
PERIOD OF COVERAGE FROM	TO

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NAME (Indicate if Not Covered or self-insured) NJ REG. OR FEIN	
ADDRESS	
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